PRINTED: 03/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING		C 12/14/2017
	ROVIDER OR SUPPLIER	ILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 00	00	
F 607 SS=D	survey was conducted 12/14/17. Complaint the survey. Correction compliance with the frederal Long Term Complete the consisted of nine curred (Residents #1 through through #15) and six (Residents #8 through Develop/Implement ACFR(s): 483.12(b)(1) §483.12(b) The facility implement written positive with the positive frederal Long Terminal Problems (Section 1988) 12(b)(1) Prohibing the properties of the frederal Long Terminal Problems (Section 1988) 12(b)(2) Establity to investigate any successful Section (Section 1988) 12(b)(3) Include paragraph (Section 1988) 13(b)(3) Include par	s were investigated during ons are required for ollowing 42 CFR Part 483 are requirements. 9 certified bed facility was survey. The survey sample rent resident reviews th #7 and Residents #14 closed record reviews th #13). buse/Neglect Policies (-(3)) y must develop and dicies and procedures that: at and prevent abuse, the cion of residents and desident property, sh policies and procedures	F 60	F607 1. Resident #10 no longer resides in facility.	1/12/18 n this
		of 15 residents in the		 Residents who sustain an injury of unknown origin have the potential to affected by this deficient practice. 	be
		to implement the facility		3. Facility staff were in-serviced by	the

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

01/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _				C 14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	14/2017
					600 AUTUMN PARKWAY		
AUTUMN	CARE OF MECHANICSV	ILLE			ECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 607	Continued From page	÷ 1	F 6	607			
	top and bottom lips or	and on top of Resident #10's			DON or designee on the abuse policy, include injuries of unknown origin. 4. Audits of resident injuries will be conducted five times weekly for twelve		
	The findings include:				weeks by the DON or designee, to determine that the source of the injury	has	
	2/12/17 with the follow the legs, depression, pain and stroke. Res from the facility on 8/4 Resident #10's most set), a quarterly asset (assessment reference Resident #10 as scor interview for mental set) Resident #10 was set decisions of daily living coded as requiring materials.	recent MDS (minimum data assment with an ARD are date) of 6/6/17 coded are four on the BIMS (brief tatus) indicating that are rerely impaired with a resident #10 was also aximum assistance of one of daily living and set up			been identified and to assure that the abuse policy has been implemented ar followed. Results of audits will be submitted to the QAPI committee for the months for review and revision as needed. 5. Date of compliance: January 16, 2018	nd	
	Text: Wound type is I upper lip. Length (cm Width (cm) 2 (two). E in house acquired. n/impairment was not p 6/30/2017 Drainage T Area is a new wound. 0/30/2017 12:00 P.M. Signed by LPN (licensunit manager"6/30/2017 11:40 (11	following notes; :40 a.m.) Type: tre Skin Assessment. Note oruising. Wound Location (a) (centimeters) 2 (two). Depth (cm) 0 (zero). Area is (a (non applicable) Skin resent on admission. Type. No Drainage. No odor. Pain Level is 0 (zero) Treatment: monitoring." (sed practical nurse) #10, a					

CLIVILIN	O I OIL WEDICARE &	WEDICAID SERVICES				CIVID IVC	7. U930-U39 I	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495413	B. WING				C 14/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				76	600 AUTUMN PARKWAY			
AUTUMN	CARE OF MECHANICSV	ILLE			IECHANICSVILLE, VA 23116			
	ı			IVI	IECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 607	bottom lip. Length (c (cm) 1 (one). Depth (house acquired. n/a impairment was not p 6/30/2017 Drainage Area is a new wound 0/30/2017 12:00 P.M Signed by LPN (licen unit manager"6/30/17 11:40 Type: (evaluation) Overview Resident noted with r cm x 2 cm oval in shatthe inside of mouth. Respurple bruising meas shape with round edga mirror image to top (complaint of) pain be assessment (sic). Read is aware of area. aware. Immediate In for any further injury.	bruising. Wound Location m) (centimeters) 0.5. Width (cm) 0 (zero). Area is in (non applicable) Skin bresent on admission. Type. No Drainage. No odor. Pain Level is 0 (zero) Treatment: monitoring." sed practical nurse) #10, a	F	807				
	family/responsible pa occurrence. (Name of with poor safety awar							
	A review of Resident plan dated 2/12/16 re documentation; "Focu breakdown d/t (due to	b) incontinence, immobility. er and lower lip. Date						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	100710	1	STREET ADDRESS, CITY, STATE, ZIP C		2/14/2017	
				7600 AUTUMN PARKWAY			
AUTUMN	CARE OF MECHANIC	CSVILLE		MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	revealed, in part, 6/30/2017: "Incide with bruising to mouth with bite m Resident also note bruising to medial to top lip. When rincident resident sand it was you. R When staff memb that she did not not that no maybe it with confusion at Injuries Observed Type: Bruise. Injuries Observed Type: Bruise. Injuries Observed Type: Bruise Injuries Observed Injur	ent #10's incident reports the following incident dated ent Description: Resident noted edial upper lip on the inside of arks noted to inside of mouth. ed with redish (sic) purple lower lip that is a mirror image esident asked to describe stated I think somebody hit me deferring to this staff member. er asked when resident stated to (sic) and proceeded to state vas not you. Resident noted baseline is alert to self only. at Time of Incident: Injury ry Location: Face. Witnesses:	F6	507			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(2
		495413	B. WING			12/	14/2017
	ROVIDER OR SUPPLIER	ILLE	•	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)				(X5) COMPLETION DATE
F 607	called her. Writer told this would be reported resident's room and make was walking onto parties walked to residaughter showed (na and told her what she of LPN #10) said that investigation. (Name daughter she would be reported to Supervisor staff member) #3, the On 12/13/17 at approof the director of nursing (facility reported incid was submitted to the Certification for an inj 7/18/17, 19 days after on Resident #10's lips was documented on the aide, she stated that attempted to take (na flatware at the dining Resident #10) moved resident struck her in knife. She stated she nurse. There were two nurse interviewed sai incident to him and he assigned to the reside said that she had not had not witnessed the counseled on reporting thorough investigation.	noticed and should have diresident's daughter that distonursing. Writer left net (name of LPN #10) as of the Spring Unit and both dent's room. Resident's me of LPN #10) the bruising shad told the writer. (Name she would begin an of LPN #10) and writer told be followed-up with. Writer or." Signed by OSM (other social worker. Eximately 3:00 p.m. ASM #2, g., provided a copy of a FRI ent) to this writer. The FRI Office of Licensure and ury of unknown origin on the FRI; "When interviewing that another resident had me of Resident #10's" table. When (name of the flatware, the other the lower face with a butter the reported this incident to a wo nurses on duty. The first distinct the aide did report the ereported to the nurse ent. The nurse assigned investigated because she incidents and conducting as per facility policy." ASM ide the full investigation for	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 12/14/2017			
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	E				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE		
F 607	A review of the facility Resident Abuse Policifollowing documentativill not tolerate abuse exploitation of resident property by a policy to investigate and incidents of abus seclusion, exploitation misappropriation of resident property by a policy to investigate and incidents of abus seclusion, exploitation misappropriation of resident property by a policy to investigate and incidents of abus seclusion, exploitation misappropriation of resident property of unknown source. An injury is classified Source" when both the met: a. The source cobserved by any persinjury could not be exand from the injury of the injury of Abuse, Neglect, Insof Unknown Source immediately to the Acondusted by the Acondusted and DOH (department investigation of the all conducted. a. Time investigation must be working days from the conducted with ASM of the	is provided to this writer by g on 12/4/17 at 8:00 a.m. If policy titled "Virginia y" revealed, in part, the ion; "POLICY: This Facility e, neglect, mistreatment, ats, and misappropriation of anyone. It is the facility's all allegations, suspicions e, neglect involuntary in of residents, esident property and injuries injury of Unknown Source; as an "Injury of Unknown e following conditions are of the injury was not ion, or the source of the plained by the resident; suspicious because of the elocation of the injury, the served at one particular cidence of injuries over is. A. Timing. All allegations yoluntary Seclusion, Injuries must be reported ministrator, Director of the applicable State ite. Once the Administrator it of health) are notified, an allegation or suspicion will be frame for investigation. The completed within five (5) is alleged occurrence."	F 6	507					
		describe the process for president altercation with a							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		l	С
	20//255 05 0//25//55	495413	B. WING			12/	14/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	on the hallway will initialls on me or the ADC nursing) to complete was asked if there was origin would a FRI be ASM #2 stated, "Yes immediately and then investigation." ASM #Resident #10's injuried ASM #2 stated that it investigated when the altercation occurred on the notified about the complained on 7/10/1 not been completed in When asked what has "Neither nurse on 6/2 resident to resident all documented and made but they did not report ASM #2 what happens spoke with the daugh the bruising. ASM #2 happened or why the reporting to the office On 12/14/17 at 4:00 pc (Administrative staff in corporate nurse (ASM #2) were made concerns.	#2 stated, "The supervisor tiate the investigation, but it ON (assistant director of the investigation." ASM #2 as an injury of unknown sent to the state agency. We need to send the FRI follow up with an #2 was asked about as to her top and bottom lips. should have been a original resident to resident an 6/28/17 but that she was incident until the daughter 7 that an investigation had an regards to the bruising. Popened ASM #2 stated, 8/17 documented about the latercation. They should have the me aware of the incident at to me and did nothing." The defer the social worker the on 6/29/17 in regards to the was unable to say what the was such a delay in the delay in the delay in the administrator member [ASM] #1), M #3) and director of nursing	F	607			
F 608 SS=D	end of the survey. Reporting of Reasons	able Suspicion of a Crime	F	608			1/12/18

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	COMPLETED	COMPLETED		
		495413	B. WING		C 12/14/2017	7		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	12/14/2017			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	ETION		
F 608	implement written p §483.12(b)(5) Ensu occurring in federall facilities in accordar Act. The policies ar but are not limited to (i) Annually notifying defined at section 1 individual's obligation reporting requireme (A) Each covered in State Agency and of entities for the politic facility is located an orime against any in or is receiving care (B) Each covered in immediately, but no forming the suspicion suspicion result in selater than 24 hours suspicion do not res (ii) Posting a consp rights, as defined at Act. (iii) Prohibiting and defined at section 1 This REQUIREMEN by: Based on staff inter review, it was deter failed to report a sus manner. The findings include	lity must develop and olicies and procedures that: re reporting of crimes y-funded long-term care nee with section 1150B of the nd procedures must include to the following elements. It is govered individuals, as 150B(a)(3) of the Act, of that on to comply with the following nts. dividual shall report to the ne or more law enforcement cal subdivision in which the y reasonable suspicion of a ndividual who is a resident of, from, the facility. dividual shall report to the report to the act than 2 hours after on, if the events that cause the erious bodily injury, or not if the events that cause the sult in serious bodily injury. icuous notice of employee a section 1150B(d)(3) of the preventing retaliation, as 150B(d)(1) and (2) of the Act. IT is not met as evidenced review and facility document mined that the facility staff spected crime in a timely	F 60	F608 1. No residents were affected by deficient practice. 2. Residents who are victims of a suspected crime have the potential affected by this deficient practice. 3. Facility staff were in-serviced to DON or designee on the abuse pole	to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
ΔΙΙΤΙΙΜΝ	CARE OF MECHANICSV	W.I.F.	7600 AUTUMN PARKWAY				
AUTOMIN	CARL OF MECHANICS	ILLE		MECHANICSVILLE, VA 23116	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA		
F 608	Health, Office of Lice "Report Date" docum "Incident Date" docum "Incident Type "Unusual occurrence "Possible diversion of to pharmacy for facilit to Board of Nursing. local law enforcemen investigation: comple The letter addressed dated 9/11/17, docum unusual set of circum (nursing license numl an acrimonious separ (LPN # 15) reported t nursing) that he woul her on her job. On S an individual brought punch card of various the bag of medication house they shared pr separation. Although on the top of the card part, removed, it was the cards had enough came from our facility of local sheriff's office typographical error - assistance. We requested a writte 15) regarding the me write a statement. Sh (Name of Deputy) on Administrator's office	firginia Department of Insure and Certification. The Lented, 9/11/17. The Inented a question mark. "I was hand written, I The form documented, of medications to be returned the ty credit. See attached letter Investigation ongoing with the transport of the Board of Nursing, mented, "We are reporting an Lestances involving # 15 Leber). Apparently related to the ration from her husband, to our DON (director of the creating problems for Leaturday, September 2, 2017 Leating and Leaturday, September 2, 2017 L	F6	include reporting of susp 4. Audits of reports of occurrences will be cond weekly for twelve weeks whether a possible crime committed. Results of au submitted to the QAPI of for three months for reviews needed. 5. Date of compliance: 2018.	unusual ducted five time to determine e has been udits will be ommittee month ew and revision	hly	

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495413	B. WING			1	C
	20/4252 02 01/22/452	495413	B. WING		ATTEST ADDRESS SITE OF THE SOCIETY	12/	14/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608	is included). It is our to which we identified as the property of the fact returned to our pharm the two residents were. One resident had disc and the other had exp. 6/23/17. We will be secover, a copy of the p. #15). She has been secontinuing our sharing cooperation with the lakeep you informed of the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed to minder the cooperation with the lakeep you informed of the provided t	the zip-lock bag. (An inventory belief, these medicine (sic) is coming from here, were cility and were to have been nacy for a facility credit since the no longer in the facility. Charged home on 2/22/17 boired in the facility on the investigation and ocal authorities. We will the investigation." The medication cards: (a) (milligrams) (an antibiotic used to tal pills (2) notal pills (2) notal pills. (4) ng (an antibiotic used to tal pills. (4) ng (an antibiotic used to tal pills. (4) ng (an antibiotic used to tal pills. (5) mg, 22 total pills. (b) mg, 22 total pills. (c) (mg, 30 total pills. (d) mg, 30 total pills. (e) (used to treat acid reflux - itills. (6) mg. (An antihistamine nausea and vomiting) 25 ng (used to treat irritable)	F	608			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(
		495413	B. WING _			12/	14/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608	used for insomnia) (1 16. Acetaminophen (1 pain and fever) 325 m 17. Acetaminophen 6 18. Prednisone (a cor inflammation) 2.5 mg 19. Prednisone 5 mg, 20. Musinex (sic) (Gu phlegm and mucus fre total pills. (13) 21. Musinex (sic) 600 22. Musinex (sic) 600 23. Musinex (sic) 600 24. Excedrin Tension documented) (contain caffeine) (used to treat (14) An interview was con staff member (ASM) and on 12/14/17 at 9:50 and her involvement with drug diversion, ASM and good nurse, she had me of the situation sh her husband and said trouble for her at her j about her. I was told the facility, I was not I - ASM #1) and I went medications. Most of off. We could figure of Those were drugs the back to the pharmacy the local police. My re-	(an antidepressant and 0) Tylenol) (used to treat milding, 30 total pills. (11) 50 mg, 28 total pills. ticosteroid used to treat, 13 total pills. (12) 9 total pills. (12) 9 total pills. aifenesin) (Used to move om the lungs) 600 mg, 20 mg, 20 total pills. mg, 20 total pills. mg, 20 total pills. Headache (no strength as Acetaminophen and at headaches) 15 total pills. ducted with administrative #2, the director of nursing, m. When asked to tell of the incident of the possible #2 stated, "She was a fairly lung cancer. She had told e was going through with I he would try to make job and would be telling lies the drugs were brought into here. (Name of administrator	F	608			

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413	B. WING		C 12/14/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		2/14/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 608	"No, (ASM #1) handle further stated, "The p pharmacy to get the converted were taken to determine." An interview was considerable and administrator, on 12/2 asked when he was for being brought into the the Friday (9/1/17) beat the facility, I got an a man. He informed diverting drugs. I instepolice or identify hims report it. He hung upspecifications to a nurse contacted the local post called her (LPN #15) deputy was in my office ASM #2) and (LPN #15) to write a statem deputy made some conditional and apparently there us that were not truth situation at home." We unusual circumstance ASM #1 stated, "Yes, been an administrato unusual case, I let the agency handle it." When asked suspected crimes in the suspected crim	any of this, ASM #2 stated, ed all of this." ASM #2 olice had us call the cost of the medications that ine if it rose to the level of a ducted with ASM #1, the 14/17 at 10:05 a.m. When irst made aware of the drugs e facility, ASM #1 stated, "On effore the medications arrived anonymous phone call from me that a nurse was tructed him to either call the self to me so that I could A man came into the 6/2/17) and gave the se on duty. On 9/5/17, I olice. A deputy came. We into the building. The ce with (LPN #15), (name of 15). (ASM #2) asked (LPN ment but she refused. The alls outside, one to a judge, were things she was telling ful in relations to her then asked if this was an e and a suspected crime, it was. Over the years I've	F 6	08			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495413 B. WING _				C 2/14/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		2/14/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 608	in part, "It is (Name of notify owners, operating agents and contractor Corporation)'s nursing referred to as 'Cover individually as 'Cover report reasonable sur Secretary and law en Covered Individuals or reasonable suspicion communicated to the facilityd. Examples considered crimes in include but are not limmanslaughter, rape, abuse, theft/robbery, us or gain, identify the	rime Reporting" documented of corporation)'s policy to ors, employees, managers, ors of (Name of g facilities (collectively ed Individuals' and orded Individual' of their duty to spicion of crimes to the officementNotification to will require that all the sare immediately administrator of the nursing of situations that would be all subdivisions would	F 608				
	(1) This information v following website: https://www.ncbi.nlm T0009528/?report=dc (2) This information v following website: https://www.ncbi.nlm T0011192/?report=dc (3) This information v following website:https://dailynhives/fdaDrugInfo.cfr	n was provided prior to exit. vas obtained from the .nih.gov/pubmedhealth/PMH etails. vas obtained from the .nih.gov/pubmedhealth/PMH etails vas obtained from the etails vas obtained from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/1-12011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 608	F 608 Continued From page 13		F 6	508			
	https://dailymed.nlm gXsl.cfm?id=44390. (5) This information following website: https://dailymed.nlm m?setid=a1f01e8e-993. (6) This information following website: https://dailymed.nlm m?setid=c63b2dd4-601. (7) This information following website: https://pubchem.ncb methazine#section=(8) This information following website: https://dailymed.nlm m?setid=ac145b81-66. (9) This information following website: https://medlineplus.g(10) This information following website: https://dailymed.nlm aDrugInfo.cfm?archi (11) This information following website: https://pubchem.ncb aminophen#section=(12) This information following website: https://pubchem.ncb aminophen#section=(13) This information following website: https://www.ncbi.nlm T0011828/?report=d(13) This information following website:	was obtained from the nih.gov/dailymed/drugInfo.cf 17e9-11de-b91d-553856d895 was obtained from the nih.gov/dailymed/drugInfo.cf 17e8-11de-b91d-553856d895 was obtained from the nih.gov/dailymed/drugInfo.cf 17e8-47a1-889b-94d68137bd was obtained from the i.nlm.nih.gov/compound/pro 17op. 17op. 18vas obtained from the 18vas obtained from the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017		
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 231		12/14/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	DATE		
F 608	following website: https://dailymed.nlm.r	was obtained from the hih.gov/dailymed/drugInfo.cf 1ac-47d2-8747-b018cda005	F	608				
F 609 SS=D			F	609		1/12/18		
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allega that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to the adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the ses where state law provides the care facilities) in the law through established						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 12/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/20	17	
				7600 AUTUMN PARKWAY				
AUTUMN	CARE OF MECHANICSV	ILLE		MECHANICSVILLE, VA 23116				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ECTION HOULD BE PROPRIAT	COME	(X5) PLETION DATE	
F 609	and clinical record revithe facility staff failed unknown origin for on survey sample, Resident The facility staff failed abuse and neglect pobruising underneath atop and bottom lips on The findings include: Resident #10 was add 2/12/17 with the follow the legs, depression, pain and stroke. Resfrom the facility on 8/4 Resident #10's most set), a quarterly asset (assessment reference Resident #10 as scor interview for mental seriodent #10 was set decisions of daily living coded as requiring maperson with activities assistance with eating A review of Resident revealed, in part, the -"6/30/2017 11:40 (11 Pressure/Non-Pressure). Length (cm. survey) as the facility of the facility	iew, facility document review view, it was determined that to report an injury of e of 15 residents in the ent #10. It to implement the facility dicy after discovering and on top of Resident #10's in 6/29/17. In the facility on wing diagnoses; swelling in difficulty with swallowing, ident #10 was discharged factor with an ARD are date) of 6/6/17 coded ing a four on the BIMS (brief tatus) indicating that everely impaired with g. Resident #10 was also aximum assistance of one of daily living and set up g. #10's progress notes following notes; 140 a.m.) Type: Interest of the facility on the progress of the following notes; 140 a.m.) Type: Interest of the facility of the facility on the progress notes following notes; 140 a.m.) Type: Interest of the facility of the facilit	F 6	F609 1. Resident #10 no longer resifacility. 2. Residents experiencing an unknown origin have the potentiaffected by this deficient practice. 3. The DON or designee in-se CNAs and nurses on the facility policy, including requirements for reporting of injuries of unknown. 4. Reports of injuries of unknown will be audited five times weekly weeks by the DON or designeer compliance. Results of audits witaken to the QAPI Committee methree months for review and revistance. Compliance date: January 2007.	injury of al to be e. erviced abuse or timely origin. own origin to assurill be onthly for ision.	n ve e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING	B. WING		C 12/14/2017	
	ROVIDER OR SUPPLIER		-	70	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	121	14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				(X5) COMPLETION DATE
F 609	Area is a new wound. 0/30/2017 12:00 P.M. Signed by LPN (licens unit manager"6/30/2017 11:40 (11 Pressure/Non-Pressure/	resent on admission. Type. No Drainage. No odor. Pain Level is 0 (zero) Treatment: monitoring." sed practical nurse) #10, a :40 a.m.) Type: re Skin Assessment. Note pruising. Wound Location m) (centimeters) 0.5. Width rem) 0 (zero). Area is in Skin impairment was not . 6/30/2017 Drainage Type. r. Area is a new wound. 0/30/2017 12:00 P.M. rg." Signed by LPN rse) #10, a unit manager. Head to Toe Eval. r. Occurrence Details: reddish bruising measuring 2 repe to medial upper lip on with bite marks noted to reddent also noted with reddish ruing 1 cm x 1 cm linear in res to medial lower lip that is repertured by the server of the	F	609			

F 609 Continued From page 17 A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 17 A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 F 609	/2017
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 17 A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 F 609 F 609	12011
A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date	(X5) COMPLETION DATE
Initiated: 3/14/16. Revision on 7/1/17. A review of Resident #10's incident reports revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found." A review of the investigation conducted by ASM (administrative staff member) #2, the director of nursing, revealed, in part the following documentation; "July 18, 2017. On 6/29/17, writer was called by (name of LPN #12) on the Spring Unit and asked to speak with (name of Resident #10's) room. Daughter pointed out bruising on resident's upper lip and then flipped it up to show bruising underneath. Resident was	

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 2/14/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		211-7/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	could not have done does not think her modes not think her modeen notified. Daught was hit by another recocurred in the past. Understands accident someone would have called her. Writer took this would be reported resident's room and she was walking onto parties walked to resident's room and told her what she of LPN #10) said that investigation. (Name daughter she would be reported to Supervise staff member) #3, the Con 12/13/17 at approach the director of nursin (facility reported incidents was submitted to the Certification for an in 7/18/17, 19 days after on Resident #10's lip was documented on the aide, she stated that attempted to take (not flatware at the dining Resident #10) moved resident struck her in knife. She stated she nurse. There were the nurse interviewed sat incident to him and her some state of the control of the stated she nurse. There were the nurse interviewed sat incident to him and her some stated to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident to him and her stated she nurse interviewed sat incident stated she nurse interviewed sat incident stated she nurse interviewed sat incident stated she nurse interviewed	uising. She feels her mother this to herself. Daughter other fell, as she would have neter wonders if her mother isident since this has Daughter said she ts happen but that she feels is noticed and should have do resident's daughter that is do to nursing. Writer left met (name of LPN #10) as to the Spring Unit and both ident's room. Resident's ame of LPN #10) the bruising is had told the writer. (Name it she would begin an expression of LPN #10) and writer told one followed-up with. Writer or." Signed by OSM (other	F 60				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017		
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DDE	12/14/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)			
F 609	had not witnessed the counseled on reportir thorough investigation #2 was asked to prove the bruises found on A full investigation was the director of nursing A review of the facility Resident Abuse Policifollowing documentate will not tolerate abuse exploitation of resident property by a policy to investigate a and incidents of abuse seclusion, exploitation misappropriation of reof unknown source. An injury is classified Source" when both the met: a. The source observed by any persinjury could not be exand b. The injury is extent of the injury, the number of injuries ob point in time, or the intime. 6) Initial Reports of Abuse, Neglect, Inford Unknown Source immediately to the Action Nursing (DON) and to Agency. 7) Investigal and DOH (departmer investigation of the all	investigated because she incident. Staff were in incidents and conducting his per facility policy." ASM ide the full investigation for Resident #10's lips. Its provided to this writer by gon 12/4/17 at 8:00 a.m. If policy titled "Virginia by" revealed, in part, the ion; "POLICY: This Facility englect, mistreatment, has, and misappropriation of anyone. It is the facility's all allegations, suspicions englect involuntary in of residents, esident property and injuries an "Injury of Unknown Source; as an "Injury of Unknown in following conditions are of the injury was not son, or the source of the plained by the resident; suspicious because of the injury, the served at one particular incidence of injuries over is. A. Timing. All allegations woluntary Seclusion, Injuries in must be reported liministrator, Director of	F	609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			С	
		495413	B. WING			12/	14/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	VILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 609	working days from the On 12/14/17 at 2:00 conducted with ASM ASM #2 was asked reporting a resident resulting injury. ASM on the hallway will infalls on me or the ALI nursing) to complete was asked if there worigin would a FRI b ASM #2 stated, "Yes immediately and the investigation." ASM Resident #10's injurity ASM #2 stated that investigated when the altercation occurred not notified about the complained on 7/10/1 not been completed When asked what he "Neither nurse on 6/1 resident to resident adocumented and may but they did not reporting to the officient on 12/14/17 at 4:00 (Administrative staff corporate nurse (ASM).	p.m. an interview was a #2, the director of nursing. To describe the process for to resident altercation with a way #2 stated, "The supervisor initiate the investigation, but it DON (assistant director of the the investigation." ASM #2 was an injury of unknown to sent to the state agency. We need to send the FRI in follow up with an #2 was asked about the state agency was asked about the original resident to resident on 6/28/17 but that she was a incident until the daughter was a pened ASM #2 stated, 28/17 documented about the waste of the incident work of the me and did nothing." The and did nothing." The complete was such a delay in the administrator	F	609			

		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		495413	B. WING		12	C 2/ 14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLETION		
F 609	Continued From page	21	F 60	09			
F C40	end of the survey.	was provided prior to the	F.0.	40		4/42/40	
F 610 SS=D	CFR(s): 483.12(c)(2)-		F 6	10		1/12/18	
	, , , ,	se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the gress.					
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified a action must be taken.					
	Based on staff intervi and clinical record rev the facility staff failed	iew, facility document review view, it was determined that to investigate an injury of e of 15 residents in the ent #10.		F610 1. Resident #10 no longer residentity. 2. Residents sustaining an injurunknown origin have the potential affected by this deficient practice	ry of Il to be		
	abuse and neglect po	and on top of Resident #10's		 The DON or designee in-ser CNAs and nurses on the abuse princluding the investigation of injurunknown origin. Audits of injuries of unknown 	viced policy, ries of		
	The findings include:			will be conducted five times a we	-		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED			
		495413	B. WING _		,	C 12/14/2017		
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	12/1-72017		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	2/12/17 with the followithe legs, depression, pain and stroke. Restrom the facility on 8/4 Resident #10's most set), a quarterly asset (assessment reference Resident #10 as scorinterview for mental second Resident #10 was sedecisions of daily living coded as requiring metal person with activities assistance with eatin A review of Resident revealed, in part, the -"6/30/2017 11:40 (12 Pressure/Non-Pressure/Non-Pressure/Non-Bressure/Non-Bressure/Non-Bressure/Non-Bressure/Non-Pressure/	Imitted to the facility on wing diagnoses; swelling in difficulty with swallowing, sident #10 was discharged 4/17. Trecent MDS (minimum data assment with an ARD ce date) of 6/6/17 coded ring a four on the BIMS (brief status) indicating that everely impaired with ang. Resident #10 was also aximum assistance of one of daily living and set up g. #10's progress notes following notes; 1:40 a.m.) Type: ure Skin Assessment. Note bruising. Wound Location (centimeters) 2 (two). Depth (cm) 0 (zero). Area is 1/40 (non applicable) Skin bresent on admission. Type. No Drainage. No odor. In Pain Level is 0 (zero) In Treatment: monitoring." Inseed practical nurse) #10, a 1:40 a.m.) Type: ure Skin Assessment. Note bruising. Wound Location and the same and the sam	F 6	twelve weeks to assure com Results of audits will be take committee monthly for three review and revision. 5. Date of compliance: Jan 2018.	en to the QAPI months for			
	(cm) 1 (one). Depth house acquired. n/a							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			7 50.251			С		
		495413	B. WING			12/1	4/2017	
	ROVIDER OR SUPPLIER	VILLE	•	STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DE	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 610	Area is a new wound 0/30/2017 12:00 P.M. Signed by LPN (licer unit manager"6/30/17 11:40 Type (evaluation) Overvie Resident noted with cm x 2 cm oval in shift the inside of mouth winside of mouth. Repurple bruising means shape with round ed a mirror image to top (complaint of) pain be assessment (sic). Reand is aware of area aware. Immediate Infor any further injury aggressive behavior range of motion to a family/responsible proccurrence. (Name with poor safety aware combative at times." A review of Resident plan dated 2/12/16 redocumentation; "Food breakdown d/t (due 6/30/17 bruise to up Initiated: 3/14/16. For A review of Resident revealed, in part, the 6/30/2017: "Incident with bruising to med	Type. No Drainage. No odor. d. Pain Level is 0 (zero) d. Treatment: monitoring." heed practical nurse) #10, a e: Head to Toe Eval. w: Occurrence Details: reddish bruising measuring 2 ape to medial upper lip on with bite marks noted to sident also noted with reddish suring 1 cm x 1 cm linear in ges to medial lower lip that is o lip. Resident without c/o hefore after during and after de (responsible party) present de MD (medical doctor) made hervention: Mouth assessed de Resident is known for at times. Resident has full at extremities. Residents arty was notified of of RP) Resident continues for RP) Resident c	F	610				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 12/14/2017	
	ROVIDER OR SUPPLIER	VILLE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	12/14/2017	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 610	bruising to medial lot to top lip. When resi incident resident star and it was you. Refe When staff member that she did not no (sthat no maybe it was with confusion at bas Injuries Observed at Type: Bruise. Injury I No Witnesses found A review of the invest (administrative staff nursing, revealed, in documentation; "July writer was called by Spring Unit and asked Resident #10's) daughallway and walked (Resident #10's) roo bruising on resident's up to show bruising asked by writer if she became bruised, and Daughter told writer not notified of the bruster.	with redish (sic) purple wer lip that is a mirror image ident asked to describe ted I think somebody hit me erring to this staff member. asked when resident stated sic) and proceeded to state s not you. Resident noted seline is alert to self only. Time of Incident: Injury Location: Face. Witnesses: ." stigation conducted by ASM member) #2, the director of	F 610	,		
	been notified. Daug was hit by another re occurred in the past. understands accider someone would have called her. Writer to this would be reporter resident's room and	other fell, as she would have hter wonders if her mother esident since this has Daughter said she hts happen but that she feels e noticed and should have ld resident's daughter that ed to nursing. Writer left met (name of LPN #10) as to the Spring Unit and both				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE S	ETED
		495413	B. WING		12/1	4/2017
				STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 12/1	4/2017
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 610	parties walked to residaughter showed (nand told her what shof LPN #10) said that investigation. (Namdaughter she would reported to Supervis staff member) #3, the On 12/13/17 at approper the director of nursing (facility reported incing was submitted to the Certification for an in 7/18/17, 19 days after on Resident #10's lip was documented on the aide, she stated attempted to take (not flatware at the dining Resident #10) mover resident struck her in knife. She stated shourse. There were the nurse interviewed saincident to him and has assigned to the resident was asked to protect thorough investigation with the director of nursing A review of the facility.	sident's room. Resident's ame of LPN #10) the bruising e had told the writer. (Name at she would begin an e of LPN #10) and writer told be followed-up with. Writer or." Signed by OSM (other e social worker. oximately 3:00 p.m. ASM #2, ag, provided a copy of a FRI dent) to this writer. The FRI e Office of Licensure and nigrry of unknown origin on er the bruises were observed as. The following conclusion the FRI; "When interviewing that another resident had ame of Resident #10's" g table. When (name of d the flatware, the other in the lower face with a butter are reported this incident to a two nurses on duty. The first aid the aide did report the me reported to the nurse dent. The nurse assigned at investigated because she incidents and conducting ons per facility policy." ASM	F 61			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODI 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	'	12/1-9/2011	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	will not tolerate abuse exploitation of resider resident property by a policy to investigate a and incidents of abus seclusion, exploitatio misappropriation of rof unknown source. An injury is classified Source" when both the met: a. The source observed by any persinjury could not be exand b. The injury is extent of the injury, the number of injuries ob point in time, or the ir time. 6) Initial Report of Abuse, Neglect, In of Unknown Source immediately to the Adnursing (DON) and the Agency. 7) Investigation of the alconducted. a. Time investigation must be working days from the Conducted with ASM	ion; "POLICY: This Facility e, neglect, mistreatment, nts, and misappropriation of anyone. It is the facility's all allegations, suspicions e, neglect involuntary n of residents, esident property and injuries Injury of Unknown Source; as an "Injury of Unknown he following conditions are of the injury was not son, or the source of the replained by the resident; suspicious because of the he location of the injury, the served at one particular he incidence of injuries over s. A. Timing. All allegations woluntary Seclusion, Injuries	F 6	10			
	resulting injury. ASM on the hallway will initialls on me or the AD nursing) to complete	o resident altercation with a #2 stated, "The supervisor tiate the investigation, but it ON (assistant director of the investigation." ASM #2 as an injury of unknown					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		495413	B. WING		1	C / 14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	_ 12	11412011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 610	ASM #2 stated, "Yes immediately and then investigation." ASM #Resident #10's injuried ASM #2 stated that it investigated when the altercation occurred on notified about the complained on 7/10/1 not been completed in When asked what hap "Neither nurse on 6/2 resident to resident all documented and made but they did not report ASM #2 what happens spoke with the daugh the bruising. ASM #2 happened or why their reporting to the office On 12/14/17 at 4:00 p (Administrative staff in corporate nurse (ASM #2) were made concerns.	sent to the state agency. we need to send the FRI follow up with an #2 was asked about s to her top and bottom lips. should have been e original resident to resident on 6/28/17 but that she was incident until the daughter 7 that an investigation had a regards to the bruising. ppened ASM #2 stated, 8/17 documented about the tercation. They should have the me aware of the incident to me and did nothing." ed after the social worker ter on 6/29/17 in regards to the was unable to say what re was such a delay in o.m. the administrator member [ASM] #1), 1 #3) and director of nursing aware of the above	F 61	0			
F 657 SS=D	end of the survey.	(i)-(iii)	F 65	57		1/12/18	
	§483.21(b)(2) A comp be-	orehensive care plan must ' days after completion of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING		1	C 2/14/2017	
	ROVIDER OR SUPPLIER	'ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the resident and their An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and cassessments. This REQUIREMENT by: Based on staff interv review, clinical record complaint investigatio the facility staff failed comprehensive care residents, Resident #	terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined to development of the e staff or professionals in ined by the resident's needs the resident. ised by the interdisciplinary assment, including both the quarterly review T is not met as evidenced friew, facility document to review and in the course of the on, it was determined that to review and revise the plan for three of 15	F 68		resides in the esidents #1 revised.		
	provided direction on following an incident struck her in the mou an injury to her mouth	keeping Resident #10 safe where another resident th with a butter knife causing		educated Interdisciplinary C members and nurses on rev updating and revising care president to resident altercation. The MDS Coordinator coreview care plans for resident	are Team riewing, blans for ons. or designee will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495413	B. WING _		C 12/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				7600 AUTUMN PARKWAY	
AUTUMN	CARE OF MECHANIC	SVILLE		MECHANICSVILLE, VA 23116	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		CORRECTION (X5) ION SHOULD BE COMPLETION HE APPROPRIATE Y)
F 657	Continued From pa	age 29	F 6	657	
	she struck Residen butter knife, causin 3. Facility staff faile	nprehensive care plan after at #10 in the mouth with a g an injury. Ed to review and revise the care #1 was struck by Resident		resident-to-resident altercal weekly for eight weeks to a compliance. Results of auc taken to the QAPI committee three months for review and 5. Date of compliance: Ja 2018.	ssure dits will be se monthly for d revision.
	The findings include	e:			
	1. The facility staff failed to review and revise Resident #10's comprehensive care plan that provided direction on keeping Resident #10 safe following an incident where another resident struck her in the mouth with a butter knife causing an injury to her mouth.				
	2/12/17 with the fol the legs, depressio	admitted to the facility on lowing diagnoses; swelling in n, difficulty with swallowing, esident #10 was discharged 8/4/17.			
	set), a quarterly as: (assessment refere Resident #10 as so interview for menta Resident #10 was s decisions of daily li coded as requiring	st recent MDS (minimum data sessment with an ARD ence date) of 6/6/17 coded coring a four on the BIMS (brief al status) indicating that severely impaired with ving. Resident #10 was also maximum assistance of one es of daily living and set up cing.			
	revealed, in part, the 6/30/2017: "Incider with bruising to me	nt #10's incident reports ne following incident dated nt Description: Resident noted dial upper lip on the inside of rks noted to inside of mouth.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/1-12017	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	bruising to medial low to top lip. When resident state and it was you. Refewhen staff member at that she did not no (state that no maybe it was with confusion at bas Injuries Observed at Type: Bruise. Injury Lendon No Witnesses found. A review of Resident plan did not reveal ar information on how to following the resident 6/28/17. On 12/14/17 at 1:00 per conducted with LPN (#13, a floor nurse wowened).	with redish (sic) purple wer lip that is a mirror image dent asked to describe ed I think somebody hit me rring to this staff member. asked when resident stated ic) and proceeded to state not you. Resident noted eline is alert to self only. Time of Incident: Injury ocation: Face. Witnesses: #10's comprehensive care by information that provided to keep Resident #10 safe to resident altercation on	F 6	57			
	LPN #13 was asked in resident altercation on "Not off the top of my not in the area when anything happen." Lift or not he had comple #13 stated that he had whether or not he had comprehensive care should have done it, On 12/14/17 at 1:15 proconducted with LPN in Resident #10's unit a resident altercation.	f he recalled the resident to n 6/28/17. LPN #13 stated, head. I remember I was it happened. I didn't see PN #13 was asked whether ted an incident report. LPN d not. LPN #13 was asked d completed a revision of the plan. LPN #13 stated, "I didn't, we got busy."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZI 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 657	Continued From page	e 31 uck in the face by another	F 6	657			
	resident. LPN #14 st nurse assistant) came We separated the two report, I did tell the ur incident to the oncom	ated, "The CNA (certified e to me and told me about it. o residents. I didn't know to nit manager and reported the ing night nurse. I should e incident but I didn't think					
	ASM #2 was asked to reporting a resident to resulting injury. ASM on the hallway will initialls on me or the AD nursing) to complete was asked if there was	o.m. an interview was #2, the director of nursing. to describe the process for to resident altercation with a #2 stated, "The supervisor tiate the investigation, but it ON (assistant director of the investigation." ASM #2 as an injury of unknown sent to the state agency.					
	immediately and then investigation." ASM # Resident #10's injurie ASM #2 stated that it investigated when the altercation occurred of	#2 was asked about s to her top and bottom lips.					
	complained on 7/10/1 not been completed in When asked what ha "Neither nurse on 6/2 resident to resident a documented and made but they did not report ASM #2 what happened spoke with the daugh the bruising. ASM #2 happened or why the	7 that an investigation had a regards to the bruising. ppened ASM #2 stated, 8/17 documented about the ltercation. They should have de me aware of the incident to me and did nothing." leed after the social worker ter on 6/29/17 in regards to a was unable to say what re was such a delay in . ASM #2 was asked what					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 12/14/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		E	12/14/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 657	the staff was instructed #10 safe following the that the staff knew to from the resident who was asked whether of comprehensive care interventions to keep stated that it had not staff would know what to protect Resident # did not know. ASM # responsible to review comprehensive care ASM #2 stated, "The resident at the time of responsible." ASM # comprehensive care revised. ASM #2 did facility policy that add requested at this time. A review of the facility revealed, in part, the The Comprehensive updated at least ever interdisciplinary team changes in the reside Plan must be updated new full MDS. V) The review the 24-Hour R changes or changes of daily living) status. coordinator will add in status to the existing Z) All direct care staff understand and follow Plan."	ed to do to keep Resident e altercation. ASM #2 stated keep Resident #10 away had struck her. ASM #2 r not Resident #10's plan was revised with Resident #10 safe. ASM #2 ASM #2 was asked how it interventions were in place 10. ASM #2 stated that she is was asked who would be and revise the plan following an incident. floor nurse working with the f the incident would be 2 was asked why the plan was not reviewed and not answer. A copy of the lresses care plans was e. / policy titled "Care Plan" following documentation; "F) Care Plan is reviewed and y 90 days by the . G) In cases of significant ent's condition. The Care d within seven (7) days of MDS Coordinator is to leport daily for significant in resident's ADL (activities The Care Planning hinor changes in resident's Care Plans on daily basis.	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S		(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 2/14/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	'	2/1-7/2011	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	Continued From pag	e 33	F 65	57			
	corporate nurse and made aware of the a	director of nursing were bove concerns.					
	No further informatio end of the survey.	n was provided prior to the					
	Resident #15's comp	ailed to review and revise brehensive care plan after #10 in the mouth with a an injury.					
	5/26/16 with diagnos	Imitted to the facility on es including, but not limited bod pressure and diabetes.					
	set), a quarterly asse (assessment referen Resident #15 as sco (brief interview for manager) Resident #15 was se	ce date) of 11/2/17 coded ring a three on the BIMS ental status) indicating that everely impaired with ng. Resident #15 was coded					
	part, the following int (certified nursing ass reported to nursing a altercation involving resident; "I was work area, when I saw (na (name of Resident # knife in her face. I to (name of Resident # so. She (Resident # resident's butter knife (sic) with the knife ag (Resident #15) from	Resident #15 and another ing Spring Unit in dining me of Resident #15) hitting 10) with the back of butter ok the knife away from 15) and asked her not to do 15) grabbed another we went back to her threating					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 12/14/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	12/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	A review of Resident plan did not reveal ar information on how to from Resident #10 for resident altercation or On 12/14/17 at 1:00 pconducted with LPN (#13, a floor nurse wo at the time of the resi LPN #13 was asked i resident altercation or "Not off the top of my not in the area when anything happen." Lift or not he had comple #13 stated that he had whether or not he had comprehensive care should have done it. On 12/14/17 at 1:15 pconducted with LPN Resident #15's unit a resident altercation. or not she remember Resident #15 struck a LPN #14 stated, "The assistant) came to me separated the two resident to the oncoming the state of the unincident to the oncoming the state of the unincident to the oncoming the state of the unincident to the oncoming the state of the state of the unincident to the oncoming the state of the state of the unincident to the oncoming the state of the state of the unincident to the oncoming the state of the state of the unincident to the oncoming the state of the s	#15's comprehensive care by information that provided be keep Resident #15 away lowing the resident to in 6/28/17. D.m. an interview was elicensed practical nurse) or rking on Resident #15's unit ident to resident altercation. If he recalled the resident to in 6/28/17. LPN #13 stated, head. I remember I was in thappened. I didn't see PN #13 was asked whether ited an incident report. LPN id not. LPN #13 was asked if completed a revision of the plan. LPN #13 stated, "I didn't, we got busy." D.m. an interview was if the time of the resident to item incident where ited the incident where ited the incident where incother resident in the face.	F	657			
	about it." On 12/14/17 at 2:00 pconducted with ASM	o.m. an interview was #2, the director of nursing.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG		Ι,	C
		495413	B. WING			1	14/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
ALITLIMAL	CARE OF MECHANICS	VII I E		760	0 AUTUMN PARKWAY		
AUTOWIN	CARE OF MECHANICS	VILLE		ME	CHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	reporting a resident resulting injury. ASI on the hallway will in falls on me or the AI nursing) to complete was asked if there worigin would a FRI b ASM #2 stated, "Yes immediately and the investigation." When Resident #15 another resident in the ASM #2 stated, "Ned documented about the altercation. They should asked what happenes spoke with the daug the bruising that was (the resident struck) was unable to say when was such a delay in #2 was asked what to keep Resident #15 and struck. ASM #2 keep Resident #15 would ASM #2 stated that was asked who would asked who wou	to describe the process for to resident altercation with a M #2 stated, "The supervisor nitiate the investigation, but it DON (assistant director of the investigation." ASM #2 was an injury of unknown e sent to the state agency.	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	Continued From page working with the resistincident would be reasked why the compreviewed and revised copy of the facility poplans was requested. On 12/14/17 at 4:00 corporate nurse and made aware of the administration of the survey. 3. Facility staff failed plan after Resident # #14. Resident #1 was administration of the survey and dementing MDS (minimum data assessment, with an date) of 10/27/17 contree out of 15 on the mental status) indicated.	dent at the time of the sponsible." ASM #2 was rehensive care plan was not d. ASM #2 did not answer. A plicy that addresses care at this time. p.m. the administrator, director of nursing were bove concerns. In was provided prior to the to review and revise the care at was struck by Resident mitted to the facility on ses that included but were not eg, irregular heart beat, falls, a. Review of the most recent	F 6	DEFICIENCY)			
	daily living except fo could perform after to Resident #14 was at 4/27/15 and readmit diagnoses that includementia, depression The most recent MD with an ARD of 11/20 requiring assistance	ssistance for all activities of reating which the resident the meal was prepared. Idmitted to the facility on ted on 12/11/17 with ded but were not limited to: n and high blood pressure. S, a quarterly assessment, D/17 coded the resident as from staff for activities of reating which the resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
				·		С	
		495413	B. WING		1	2/14/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE	•	STREET ADDRESS, CITY, STATE, ZIP 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 657	On 12/13/17 at 5:00 pall fall investigations of (administrative staff in nursing. On 12/14/17 at 7:30 a received. Included in investigation dated 9/documented, "Incider Description: Writer winursing assistant) that another resident. Wit stated that she saw releg by another resided. Review of the nurse's p.m. documented, "Owas sitting in her who station when another right leg. No injuries in and MD (medical documented). The station when another right leg. No injuries in and MD (medical documented). The station when another right leg. No injuries in and MD (medical documented). The station when another right leg. No injuries in and MD (medical documented). The station was sitting in her who station when another right leg. No injuries in and MD (medical documented). The station was sitting in her who station when another resident displayed no pain or station. The station was sitting in her who station when another resident displayed no pain or another resident altervention; as we stated, admission to see if the asked are they notified resident altercation, of a one on one with the did that, OSM #2 station was station when another resident altercation, of a one on one with the did that, OSM #2 station was station was station was station.	o.m. a request was made for for Resident #1 from ASM nember) #2, the director of a.m. the investigations were the investigations was an (8/17 at 3:21 p.m. which at Description. Nursing as notified by CNA (certified at resident had been hit by nesses. CNA (name of staff) esident get hit on the right nt." Is note dated 9/8/17 at 3:21 recurrence Details: Resident selchair in the nurses (sic) resident punched her in the noted. RP (responsible party) etor) notified. Immediate is separatedResident discomfort." It's care plan did not tion regarding the incident. ducted on 12/14/17 at 8:20 resident worker's	F	657			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		495413	B. WING			C 12/14/2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	asked if this would be stated, "I would hope would be care planned on't know." When a incident between Re OSM #2 stated that the An interview was cor a.m. with LPN (licens resident's nurse. Whe followed when there altercation, LPN #1 seport and it triggers document it." When a consequences could struck by another res "Physical injury." When such a consequences could struck by another res "Physical injury." When such a consequences could struck by another res "Physical injury." When such a consequences could struck by another res "Physical injury." When such a consequences could struck by another res "Physical injury." When such a consequences could struck by another res "Physical injury." When such as the	e documented, OSM #2 e so." When asked if this ed, OSM #2 stated, "Gosh, I sked if she was aware of the sident #1 and Resident #14, they were not on her units. Inducted on 12/14/17 at 8:35 sed practical nurse) #1, the en asked the process staff was a resident to resident our assessment and we asked what possible occur after a resident was sident, LPN #1 stated, en asked if there could be a LPN #1 stated, "Definitely. Inducted on 12/14/17 at 9:30 the social worker for Resident the would be notified if there sident altercation, OSM #3 all me to talk to the resident kay. If it kept happening we exparate units." When asked if thented, OSM #3 stated, about the altercation between sident #14 OSM #3 stated, "I	F 65	57		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	` '	ATE SURVEY DMPLETED
		495413	B. WING		1	C 12/14/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 657	their care So everyor can have input. I've or (Resident #1's unit) for plans have been a lift a care plan was updatchanges in condition might have a negative after being struck by stated, "Well that's a ask her. We would knasked if this would be #2 stated, "Absolutely An interview was con a.m. with ASM #2, the asked why a resident stated, "So staff known and we're aware of a concerns." When ask reviewed and revised altercation, ASM #2 the resident who was structured asked if the care plar resident who was structured asked if the care plar resident who was structured. "POLIC of care will be establicated in accordance regulatory requiremed basis. PROCEDURE develop a comprehent resident that includes timetables to meet the	"So we can have a plan for one can follow and everyone only been over here or two weeks and the care esaver." When asked when ated, RN #2 stated, "Falls," When asked if a resident e psychological outcome another resident, RN #2 good question. We would now if she was upset." When added to the care plan, RN y." Inducted on 12/14/17 at 11:10 e director of nursing. When thad a care plan, ASM #2 whow to care for the resident my actual or potential ated if the care plan would be differ a resident to resident stated it would be updated for the text at the other resident. When the would be updated for the uck ASM #2 did not respond. Ware of the findings at that are of the findings at that the same on an as needed in the care plan for each is measurable objectives and the resident's medical, and psychosocial needs that	F 65	57		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING			l	c
NAME OF PR	ROVIDER OR SUPPLIER	495415	D. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE	12/	14/2017
AUTUMN	CARE OF MECHANICSV	ILLE		76	00 AUTUMN PARKWAY ECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	in the resident's cond be updated within sev MDS'.	cases of significant changes ition, The Care Plan must ven (7) days of new full	F	657			
F 842 SS=D	No further information Resident Records - Io CFR(s): 483.20(f)(5),		F	342			1/12/18
	(i) A facility may not resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a coagrees not to use or o	lease information that is					
	· ·	rdance with accepted Is and practices, the facility al records on each resident ented; e; and					
	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay	r their resident permitted by applicable law;					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495413	B. WING		C 12/14/2017	
	/ILLE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 12/14/2011	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research periodical examiners, for a serious threat to he by and in compliance \$483.70(i)(3) The fact record information again authorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yeallegal age under State \$483.70(i)(5) The medici (ii) A record of the residing A record of the residing three comprehens provided; (iv) The results of any and resident review of determinations conductively Physician's, nurse professional's progree (vi) Laboratory, radio services reports as retained to the resident review of th	activities, reporting of abuse, violence, health oversight dadministrative proceedings, poses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512. Cality must safeguard medical gainst loss, destruction, or larecords must be retained required by State law; or are date of discharge when ent in State law; or ars after a resident reaches e law. Addical record must containion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; e's, and other licensed se notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced view, facility document	F 84	F842	in the	
			facility. The medical records of resident		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, f a serious threat to he by and in compliance §483.70(i)(3) The face record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The me (i) Sufficient informat (ii) A record of the res (iii) The comprehens provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on staff interv review, and clinical re- review, and clinical re-	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced	A BUILDIN 495413 B. WING CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. \$483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. \$483.70(i)(4) Medical records must be retained for- (ii) The period of time required by State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. \$483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (iii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	ROWDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD (IN FOR public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, research purposes, research purposes, research pu	

		'IDENTIFICATION NITIMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>		
ALITLIMNI	CARE OF MECHANICSV	II 1 E		7600 AUTUMN PARKWAY			
AUTOMIN	CARE OF WECHANICSV	ILLE		MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		N
F 842	Continued From page	e 42	F 84	42			
				#1 and #15 cannot be correcte 2. Residents with medical re the potential to be affected by deficient practice. 3. The DON or designee in-s	ecords have this	ve	
	document that mouth ADL (activities of dail) 2017.	care was provided on the y living) tracker in June		CNAs and nurses on accurate documentation. 4. Audits of ADL, and nursing documentation will be conduct	and timel g ed five		
	resident hit Resident butter knife.	iled to document when a #10 in the mouth with a		times weekly for twelve weeks compliance. Results of audits taken to the QAPI meeting mo three months for review and re	will be nthly for evision.	3	
	-	ne facility staff failed to document when dent #15 hit another resident in the mouth a butter knife.		5. Date of compliance: Janua 2018.	ary 16,		
	The findings include:						
	10/21/16 with diagnost not limited to history of unspecified neck of Non-Alzheimer's Dem disorder, age related fibrillation. Resident (minimum data set) a assessment with an Adate) of 10/27/17. Rebeing severely cognit make daily decisions 15 on the BIMS (brief exam. Resident #1 wextensive assistance most ADLS (activities)	nentia, anemia, anxiety osteoporosis and atrial #1's most recent MDS ssessment was a quarterly ARD (assessment reference esident #1 was coded as ively impaired in the ability to scoring 03 out of a possible interview for mental status) was coded as requiring with one staff member for of daily living).					
	living) log dated June	1's ADL (activities of daily 2017, revealed multiple under ADL task "Mouth					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	signatures indicating provided: 6/12/17 through 6/15 through 3 p.m.) shift 6/18/17 through 6/15 11 p.m.) shift. When asked who wa oral care, CNA #3 st care in the morning a that nursing aides wibrushing her teeth. concerns with Resid care. CNA #3 stated care to Resident #1. care is documented, is documented unde asked what blanks in #3 stated that blanks aide forgot to docum provided. CNA # 3 s should never leave a report. On 12/14/17 at 1:41 conducted with RN # and she would know if there are blanks or stated, "I wouldn't kr in the chart." RN #6 documented. RN #6 allegation.	ates and shifts did not have that mouth care was 5/17 and 6/20/17 7-3 (7 a.m. graph of the policy o	F 8	42			
	(administrative staff	SM #2, the DON (Director of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405442	B. WING			l	0
		495413	B. WING			12/	14/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	concerns. No further prior to exit. A policy of	information was presented	F	842			
	resident hit Resident a butter knife. Resident #10 was add 2/12/17 with the follow the legs, depression,	iled to document when a #10 in the mouth with a mitted to the facility on ving diagnoses; swelling in difficulty with swallowing, ident #10 was discharged 4/17.					
	set), a quarterly asset (assessment reference Resident #10 as scori interview for mental s Resident #10 was set decisions of daily living coded as requiring ma	te date) of 6/6/17 coded ing a four on the BIMS (brief tatus) indicating that werely impaired with ag. Resident #10 was also aximum assistance of one of daily living and set up					
	reveal any documents that occurred on 6/28 struck her in the mout a bruise to Resident #	#10's clinical record did not ation regarding an incident /17 when another resident th with a butter knife causing #10's lips. #10's incident reports (not ord) revealed, in part, the					
	following incident date	ed 6/30/2017: "Incident t noted with bruising to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	medial upper lip on the marks noted to inside noted with redish (sic lower lip that is a mirroresident asked to desstated I think someboom Referring to this staff member asked when not no (sic) and procedit was not you. Resid baseline is alert to set Time of Incident: Inju Location: Face. Witner found." A review of the facility incidents) revealed, in 7/18/17 with an invest found on Resident #1 conclusion of the invest that Resident #10 has with a butter knife. On 12/14/17 at 1:00 pc conducted with LPN (#13, a floor nurse wor at the time of the resident altercation be another resident on 6 "Not off the top of my not in the area when it anything happen." LF or not he had comple #13 stated that he has whether or not he had	e inside of mouth with bite of mouth. Resident also purple bruising to medial or image to top lip. When cribe incident resident dy hit me and it was you. Imember. When staff resident stated that she did reded to state that no maybe ent noted with confusion at lif only. Injuries Observed at ry Type: Bruise. Injury resses: No Witnesses FRIs (facility reported in part, a FRI completed on tigation into the bruising O's mouth on 6/30/17. The estigative process revealed in been struck in the mouth I.m. an interview was licensed practical nurse) reking on Resident #10's unit dent to resident altercation. If he recalled a resident to retween Resident #10 and 1/28/17. LPN #13 stated, head. I remember I was thappened. I didn't see PN #13 was asked whether the dan incident report. LPN dinot. LPN #13 was asked if documented anything in PN #13 stated, "I should"	F	342			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 12/14/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		12/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	conducted with LPN Resident #10's unit a resident altercation. or not she remember Resident #10 was str resident. LPN #14 st nurse assistant) cam We separated the two report, I did tell the unincident to the oncomhave documented the about it." On 12/14/17 at 2:00 conducted with ASM ASM #2 was asked we staff should have documented the progress notes. ASM should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with as a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with as a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with a sked was a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with a sked was a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with a sked was a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident #10 conducted with a sked was a sked we staff should have been docopy of the facility podocumenting in the colinical record was resident.	b.m. an interview was #14, a floor nurse working on t the time of the resident to LPN #14 was asked whether ed the incident where ruck in the face by another rated, "The CNA (certified the to me and told me about it. to residents. I didn't know to nit manager and reported the ning night nurse. I should the incident but I didn't think b.m. an interview was #2, the director of nursing. Whether or not the nursing the tumented the incident 0 and another resident in the M #2 stated that the incident cumented and it was not. A licy that addresses linical record/complete	F 8	42		
	end of the survey.	n was provided prior to the				
		illed to document when ther resident in the mouth				
	Resident #15 was ad	mitted to the facility on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 12/14/2017	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 842	to; dementia, high bl Resident #15's most set), a quarterly asse (assessment referent Resident #15 as sco (brief interview for m Resident #15 was se decisions of daily livi as having no behavior A review of Resident reveal any documenthat occurred on 6/20 resident in the mouth dinner causing an inj There were no incide Resident #15 striking A review of the facilit incidents) revealed, 7/18/17 with a correst to Resident #15 strik 6/28/17 with a butter On 12/14/17 at 1:00 conducted with LPN #13, a floor nurse we at the time of the res LPN #13 was asked resident altercation by	recent MDS (minimum data essment with an ARD ce date) of 11/2/17 coded ring a three on the BIMS ental status) indicating that everely impaired with ng. Resident #15 was coded ors. ##15's clinical record did not tation regarding an incident 8/17 when she struck another in with a butter knife during jury to the other resident. Exp FRIs (facility reported in part, a FRI completed on sponding investigation related ing another resident on	F8				
	"Not off the top of my not in the area when anything happen." L or not he had comple	y head. I remember I was it happened. I didn't see .PN #13 was asked whether eted an incident report. LPN ad not. LPN #13 was asked					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 2/14/2017	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
F 842	the progress notes. I have done it, I didn't, On 12/14/17 at 1:15 p conducted with LPN 7 Resident #15's unit a resident altercation. or not she remember resident was struck ir LPN #14 stated, "The assistant) came to me separated the two resident to the oncombave documented the about it." On 12/14/17 at 2:00 p conducted with ASM ASM #2 was asked we staff should have documented the about it." On 12/14/17 at 2:00 p conducted with ASM ASM #2 was asked we staff should have documented the about it." On 12/14/17 at 2:00 p corporate notes. ASM should have been documenting in the collinical record was recorporate nurse and made aware of the about it.	d documented anything in LPN #13 stated, "I should we got busy." o.m. an interview was #14, a floor nurse working on the time of the resident to LPN #14 was asked whether ed the incident where and the face by Resident #15. CNA (certified nurse and told me about it. We sidents. I didn't know to nit manager and reported the ing night nurse. I should a incident but I didn't think o.m. an interview was #2, the director of nursing. Whether or not the nursing umented the incident 5 and another resident in the 1 #2 stated that the incident cumented and it was not. A licy that addresses inical record/complete quested at this time.	F 8-	42			